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Family Physicians and Inpatient Care in the Era of the Hospitalist

Introduction

As market based health care reform progresses in the United States, family physicians are affected in new ways. One significant evolution is the use of inpatient admitting teams, commonly referred to as “hospitalists,” to care for hospitalized patients. The use of hospitalists is by no means a new phenomenon. One Florida multispecialty group has been using hospitalists since 1987.¹ The use of hospitalists is increasingly common, especially in California, where managed care market penetration is typically higher than in other parts of the country.

Family physicians graduate from residency training with a broad range of skills applicable in both inpatient and outpatient settings. Unique among all medical specialties, family medicine prides itself on being able to provide continuous “cradle to grave” health care. For this reason, many family physicians strongly oppose the concept of “handing off” their patients to another physician for hospital care.

There are a number of forces driving the use of hospitalists. Chief among them is the search for increasing efficiency in our health care system. Large HMOs assert that cost savings can be realized by having full-time inpatient care physicians available. One regional Kaiser Permanente hospital achieved a half-day reduction in average length of stay within six months of converting to the use of full-time inpatient care teams. A Salt Lake City-based health care consultant estimates that hospitalists can reduce days-per-thousand between 5 and 15 percent.² On a practical level, many family physicians who are already overburdened with their outpatient practices struggle to make rounds at the hospital. Other proponents assert that due to managed care, hospitalization is put off until absolutely necessary, and that sicker inpatients need the care of more skilled physicians.

Overview of the Hospitalist Model

One definition of a hospitalist is “a physician who spends 25 percent or more of his or her time in the hospital setting, working as physician-of-record after accepting ‘hand-offs’ of hospitalized patients from primary care physicians (PCPs), returning patients to care of the primary care physician at discharge.”³

Four stages have been noted in the evolution of hospitalist models. In stage one, PCPs manage all their own inpatient care. In stage two, PCPs organize into groups and members take turns, one at a time, caring for all hospitalized patients. In stage three, inpatient admitting teams have been established, but their use is optional. In stage four, the final stage, the use of inpatient admitting teams is mandatory.⁴

Recent experience suggests that medical groups in California are abruptly moving toward the use of hospitalists, often on a mandatory basis. There have been at least two instances in which independent practice associations (IPAs) were considering moving to the mandatory use of hospitalists. After intervention by CAFFP, the move to inpatient admitting teams is being re-examined by both IPAs.

Hospitalist models in California take a variety of forms. A La Jolla medical group uses rotating schedules of primary care physicians to act as the “dedicated admitting physician” in week-long shifts.⁵ A large San Francisco medical group uses full-time hospitalists to provide inpatient care for primary care physicians on a voluntary basis. A third provider group endorses a model in which hospitalists become involved with medical admissions at the emergency department, assist in care of medical problems that prolong

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Implications for Family Physicians

length of stay (e.g., diabetes), assist with transitioning of patients (e.g., ICU, skilled nursing), and assist with discharge planning.⁶

A CAFP survey conducted in the fall of 1997 indicated that the use of hospitalists was commonplace in urban areas, including Sacramento, the San Francisco Bay Area, San Jose, and Santa Barbara, as well as in Orange, Los Angeles, Riverside, and San Diego counties. Similarly, a California Medical Association (CMA) survey found that three out of four responding hospitals were using inpatient physicians to some degree. Of those hospitals not yet using inpatient admitting teams, half were considering their use.⁷

The use of hospitalists has wide-ranging consequences for family physicians. Areas of particular concern include:

Hospital Privileges. As attractive as a solely outpatient practice may seem, consideration must be given to maintenance of hospital privileges. Over time, insufficient inpatient volume will lead to loss of privileges or reduction from active to courtesy status. Once privileges are voluntarily given up or lost because of low volume, they would be extremely difficult to regain without the physician being proctored. Some discussion has been given to an alternate medical staff category for physicians in good standing who do not care for hospitalized patients. This may be useful for seasoned physicians, but fails to address how future classes of graduating residents will obtain hospital privileges if they are never given the opportunity to establish inpatient skills.

Family physicians should have access to inpatient admitting teams and not be excluded based on specialty. An equitable approach to establishing hospitalist panels is to compare the training, experience, and demonstrated competence of all interested physicians. This way, family physicians who want to maintain their inpatient skills will be able to do so.

Patient Care. Little or no data exists to support whether or not continuity of care improves patient outcomes. As for patient satisfaction, anecdotal evidence suggests that patients are accepting of care received by hospitalists. CAFP's survey research indicates that patients were largely satisfied with the quality of care they received from their inpatient physicians.⁸ Other comments revealed that because managed care patients are used to seeing a variety of physicians, seeing someone new in the hospital was not unexpected. Other sources indicate a similar level of satisfaction among patients.⁹

Residency Training. Residency programs stand to be greatly affected by the use of hospitalists in coming years. In some teaching hospitals, inpatient admitting teams are reluctant to let residents round on their patients because of the perception that residents will increase the cost of inpatient care. Another impact is that more and more inpatient teaching is being done by non-family physicians, depriving family practice residents of a perspective on inpatient care that is unique to the specialty. On the other hand, if family practice training were to leave the hospital altogether, residents would be denied the benefit of cross-specialty fertilization.

Communication. For those family physicians working with hospitalists, it is imperative that the system be refined to ensure the highest quality of care and the smoothest possible transition to the inpatient setting for patients. According to CAFP's survey, by far the chief complaint about the new model pertained to poor communication between primary care physicians and hospitalists. The CMA found that only half of those hospitals using inpatient physicians had protocols for contact by telephone, email, or fax to promote continuity of care at admission, during hospitalization, and at discharge. Clearly, there is more that can be done to improve the hospitalist model.

Economic Impact on Family Physicians. Preliminary information gathered by CAFP suggests that hospitalists have not yet affected FP income, however a number of responses were inconclusive. Clearly, those working in a largely fee-for-service environment stand to lose the most. It is difficult to say how medical groups working in a capitated environment will structure compensation in a hospitalist model. Some have seen hospital care as a

“carve-out” and reduced capitation rates accordingly. Other medical groups have established inpatient care teams as a service to primary care physicians without lowering primary care capitation rates.

Perhaps hardest of all to determine is the long-term economic impact that the absence of a hospital practice will have on family physicians. Some have suggested that it will be difficult for payors, health plans, consumers, and policy makers to differentiate between outpatient family physicians and midlevel practitioners. Hard-won hospital privileges and respect as a board-certified specialty may be in jeopardy, as lack of regular contact with consultants and colleagues from other specialties in the hospital setting reduces the status of the family physician.

Benefits to Family Physicians. Family physicians, whose training emphasizes the outpatient setting, have traditionally been very comfortable in this arena. Perhaps this is why many family physicians have given up hospital practice willingly. In medical groups that don't reduce capitation to pay for hospitalists, family physicians should be able to realize an increase in income due to improved practice efficiency. From the lifestyle perspective, some family physicians welcome not having to go to the hospital for late night or weekend admissions. On a clinical level, sicker outpatients make outpatient practice more challenging than ever before, and many family physicians find more than enough stimulation and professional satisfaction in outpatient work.

CAFP Policy on the Use of Hospitalists

The California Academy of Family Physicians wants to ensure that each family physician has a satisfying professional practice, whether or not it includes the care of hospitalized patients. To this end, CAFP would like to ensure that the hospitalist trend evolves in a rational manner that allows for the highest quality of patient care and fairness to all involved. It is the policy of CAFP that:

- ❖ the decision of whether or not a family physician is going to provide hospital care should be an individual choice based on the needs of his or her patients;
- ❖ family physicians should maintain their current competence in inpatient care and not voluntarily relinquish their hospital privileges;
- ❖ health plans, medical groups, hospitals, or other entities establishing inpatient admitting teams should make the use of hospitalists voluntary, not mandatory;
- ❖ family physicians should have equal opportunity to be considered for hospitalist positions and selection to inpatient admitting teams should be made based on education, experience, and demonstrated competence.

Advice for Family Physicians

Family physicians will be affected by the emergence of hospitalists. The following recommendations will help you evaluate the potential impact on your practice.

If you are facing mandatory use of inpatient admitting teams:

- ❖ Familiarize yourself with the governance and decision-making processes of the IPAs, medical groups, and hospitals with which you are involved. Play an active role in these organizations so that decisions aren't made without your input. Don't hesitate to advocate for your right to due process.
- ❖ Attend board meetings and other forums to stress the benefits of using hospitalists on a voluntary basis, including the fact that this model:
 - 1) allows family physicians to practice within the full scope of their training and competence;
 - 2) provides an incentive for hospitalists to be excellent care-givers and communicators so they can get “repeat business”;
 - 3) allows physicians to acclimate to having others care for their hospitalized patients.

- ❖ Entities requiring the use of hospitalists should ensure a mechanism for you to maintain your hospital privileges including occasional inpatient care opportunities, CME, and proctoring.

If you are considering relinquishing care of hospitalized patients:

- ❖ Acquaint yourself with the inpatient care team members, become familiar with their training and experience, and assess the care they will provide.
- ❖ Work to establish formal mechanisms for clear, consistent communication between hospitalists and primary care physicians to ensure continuity of care between inpatient and out-patient settings.
- ❖ Play an active role in the quality improvement process to help assess and improve the care your patients receive in the hospital.
- ❖ Consider the short and long term effect this will have on your income. How will you differentiate yourself from midlevel practitioners so that you are still an attractive health care provider choice?
- ❖ Research what effect lack of an inpatient practice would have before surrendering inpatient privileges and skills. Family physicians without hospital privileges may be ineligible for some health plan provider panels.
- ❖ Consider how the stature of family practice would be affected in your community if family physicians abandon the hospital en masse. Opportunities for hospital medical staff stewardship and contact with other specialties may vanish if you're no longer working in the hospital.

If you are considering becoming a hospitalist:

- ❖ Determine whether you have the skills and competence to be a viable candidate over the long term. Interest in hospital work is mounting and suggests that competition for such panels may be fierce.
- ❖ Examine how to ensure that you continue to be a board-certified family physician if you work continuously in the hospital. The ABFP re-certification examination is heavily weighted toward outpatient care.
- ❖ Devise a long-term plan for your practice. How will your outpatient practice be affected by your inpatient work and how will you re-build your patient base if in the future you no longer want to do hospital work?
- ❖ Consider what type of compensation you are offered for hospital work. Is it more or less than you would be making in the outpatient setting? Is it worth becoming a hospitalist? ❖

Notes

- 1 Henry, Leigh Ann, Will Hospitalists Assume Family Physicians' Inpatient Care Roles, *Family Practice Management*, July/August 1997, p. 55-69.
- 2 Henry, op. cit.
- 3 Proceedings from "Management of the Hospitalized Patient in the Managed Care Era," a conference held in San Francisco, California, April 10, 1997.
- 4 Boschert, Sherry, 'Hospitalists' May Be an Emerging Specialty, *American Medical News*, July 15, 1997, p. 67.
- 5 California Medical Association Memorandum, Retention of Hospital Privileges for Primary Care Physicians, October 1, 1997.
- 6 California Medical Association, op. cit.
- 7 California Medical Association, op. cit.
- 8 Survey conducted by California Academy of Family Physicians, September, 1997.
- 9 Henry, op. cit.

The mission of the California Academy of Family Physicians is to enhance, strengthen, and promote the specialty of family medicine, to promote professional and personal growth for its members, and to advocate for family-centered care for all Californians. For more information about hospitalists or other issues, please contact the Academy by phone, 415/345-8667; fax, 415/345-8668; email, CAFP@Familydocs.org; or mail, 1520 Pacific Avenue, San Francisco, California, 94109-2627. ❖